1840 Lake

Lake County, Ohio

ENROLLMENT APPLICATION AND CHANGE FORM

BENEFIT ELECTIONS

☐ NAME CHANGE ☐ ADDRESS CHANGE

DEPARTMENT NAME: _____ **EMPLOYEE #** _____

Employee Information

Last Name _____ **First Name** _____ **Date of Birth** _____

Social Security Number _____ **Date of Hire** _____

Full Address _____

Marital Status **Single** ☐ **Married** ☐ **(If married, Spousal Surcharge Form must be completed)** **Spousal Surcharge Yes** ☐ **No** ☐

(A) Add (T) TERM (C) CHANGE **EFFECTIVE DATE:**

	Dependents Full Name	SSN	Date of Birth	Relationship	M/F
	Spouse				
	1.				
	2.				
	3.				
	4.				
	5.				
	6.				
	7.				

Medical and Rx Plan Election

Bi-Weekly Payroll Deductions

***New 4-tier rate structure**

EFFECTIVE INSURANCE DATE _____

Please select one

ANTHEM	EPO	PPO
EMPLOYEE ONLY (EE)	☐	☐
EE & Spouse	☐	☐
EE & Child	☐	☐
Family	☐	☐

Decline Medical and Rx ☐

*Employees who completed health screenings at the Health Fair will be eligible for a discount on their medical premiums.

Dental Plan Election

Bi-Weekly Payroll Deductions

Sun Life	NAP	PPO
EMPLOYEE ONLY (EE)	☐	☐
EE & Spouse	☐	☐
EE & Child	☐	☐
Family	☐	☐

Decline Dental ☐

EyeMed Vision Election

Monthly Payroll Deductions

EyeMed	Voluntary Plan
EMPLOYEE ONLY (EE)	$4.01 ☐
EE + 1	$7.43 ☐
EE + Family	$10.82 ☐

Decline EyeMed Vision ☐

PLEASE CIRCLE SPOUSE OR CHILD

Lake County, Ohio

BENEFIT ELECTIONS CONTINUED

I understand that by signing this form, I make a binding election concerning my benefits for the next plan year. I also understand that I will not be able to change my election prior to next open enrollment period unless I have a qualified life event. In addition, I understand my duty to notify Personnel Division within 30 days of any changes that affect the eligibility of any of my covered dependents; for example, marriage, divorce, or change in dependent status.

I understand that enrolling a dependent that is not eligible or failing to provide notice of ineligibility can result in retroactive termination of health plan coverage for me and my dependents. I also understand that coverage of an ineligible dependent will result in liability on my part for costs by the Plan while my dependent was ineligible.

I certify that all information provided in this enrollment form is correct to the best of my knowledge and authorize release of any information to the appropriate vendors as requested with respect to this enrollment. I understand that Lake County, at its sole discretion, may rescind my coverage at any time on the basis of any untrue, inaccurate or incomplete information provided on this form, or any misrepresentation, omission or concealment on this form, whether intentional or otherwise. I further understand if coverage is issued, it will be issued by Lake County, in full reliance and in consideration of the information, answers and statements contained herein.

WARNING: Any person who, with intent to defraud or knowing that he is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Signature: _____

Name: _____ **Date:** _____